Anthem Blue Cross and Blue Shield
Anthem Silver GuidedAccess Plus - gfpa

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 – 12/31/2014
Coverage for: Individual + Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling (855) 748-1805.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** person / **$4,000** family for In-Network Provider. Does not apply to Copayments, Prescription Drugs, and Preventive Care.	You must pay all costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes; $250 person / $500 family for In-Network Provider for Tier 2 & Tier 3. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes; **$6,350** person / **$12,700** family for In-Network Provider.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, Balance-Billed charges, and Health Care This Plan Doesn't Cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No; This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes; See **www.anthem.com** or call **(855) 748-1805** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.

Questions: Call (855) 748-1805 or visit us at www.anthem.com
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (855) 748-1805 to request a copy.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	Yes, you need written approval to see a specialist. There may Be some providers or services for which referrals are not required. Please see the formal contract of coverage for details.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Network provider** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay for first 3 visits and then 30% coinsurance	Not covered	Copay applies to the first three office visits, then deductible and coinsurance apply
	Specialist visit	$35 copay for first 3 visits and then 30% coinsurance	Not covered	Copay applies to the first three office visits, then deductible and coinsurance apply
	Other practitioner office visit	Chiropractor $35 copay for first 3 visits and then 30% coinsurance Acupuncturist Not covered	Chiropractor Not covered Acupuncturist Not covered	Chiropractor Copay applies to the first three office visits, then deductible and coinsurance apply Acupuncturist --------none--------
	Preventive care/screening/immunization	No charge	Not covered	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab - Office 30% coinsurance X-Ray – Office 30% coinsurance	Lab - Office Not covered X-Ray – Office Not covered	Lab - Office Costs may vary by site of service. You should refer to your formal contract of coverage for details. X-Ray – Office Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage. Costs may vary by site of service. You should refer to your formal

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
				contract of coverage for details.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	$15 copay per prescription (retail only) and $38 copay per prescription (mail order only)	Not covered	You pay additional copays for retail fills that exceed a 30 day supply. Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (mail order or retail program).
	Tier 2 - Typically Preferred/Formulary Brand	$35 copay per prescription (retail only) and $88 copay per prescription (mail order only)	Not covered	You pay additional copays for retail fills that exceed a 30 day supply. Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (mail order or retail program).
	Tier 3 – Typically Non-preferred/Non-formulary and Specialty Drugs	$70 copay or 30% coinsurance, whichever is greater up to $500 per prescription (retail only) and $175 copay or 30% coinsurance, whichever is greater up to $1,250 per prescription (mail order only).	Not covered	You pay additional copays for retail fills that exceed a 30 day supply. Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (mail order or retail program).
	Tier 4 -Typically Specialty Drugs	$70 copay or 30% coinsurance, whichever is greater up to $500 per prescription (retail only) and $175 copay or 30% coinsurance, whichever is greater up to $1,250 per prescription (mail order only).	Not covered	You pay additional copays for retail fills that exceed a 30 day supply. Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (mail order or retail program).

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	--------none--------
	Physician/surgeon fees	30% coinsurance	Not covered	--------none--------
If you need immediate medical attention	Emergency room services	30% coinsurance	30% coinsurance	--------none--------
	Emergency medical transportation	30% coinsurance	30% coinsurance	--------none--------
	Urgent care	30% coinsurance	30% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fee	30% coinsurance	Not covered	--------none--------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit $35 copay for first 3 visits and then 30% coinsurance Mental/Behavioral Health Facility Visit-Facility Charges 30% coinsurance	Mental/Behavioral Health Office Visit Not covered Mental/Behavioral Health Facility Visit-Facility Charges Not covered	Mental/Behavioral Health Office Visit --------none-------- Mental/Behavioral Health Facility Visit-Facility Charges Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Mental/Behavioral health inpatient services	30% coinsurance	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Substance use disorder outpatient services	Substance Abuse Office Visit $35 copay for first 3 visits and then 30% coinsurance Substance Abuse Facility Visit - Facility Charges 30% coinsurance	Substance Abuse Office Visit Not covered Substance Abuse Facility Visit - Facility Charges Not covered	Substance Abuse Office Visit --------none-------- Substance Abuse Facility Visit -Facility Charges Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Substance use disorder inpatient services	30% coinsurance	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage. Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	30% coinsurance	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage. Applies to inpatient facility. Other cost shares may apply depending on services provided.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	--------none--------
	Rehabilitation services	$35 copay and then 30% coinsurance	Not covered	Coverage for speech therapy is limited to 20 visits per calendar year, physical therapy is limited to 20 visits per calendar year, and occupational therapy is limited to 20 visits per calendar year. In-Network. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Habilitation services	$35 copay and then 30% coinsurance	Not covered	Apply to In-Network Providers. Costs may vary by site of service. You should refer to your formal contract of coverage for details. Habilitation and Rehabilitation visits count towards your Rehabilitation limit.
	Skilled nursing care	30% coinsurance	Not covered	Coverage is limited to 100 days per calendar year. Apply to In-Network Providers. Failure to obtain preauthorization may result in non-coverage or reduced coverage. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Durable medical equipment	30% coinsurance	Not covered	--------none--------
	Hospice service	0% coinsurance	Not covered	--------none--------

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No charge	Total cost less $30 Reimbursement	Coverage is limited to 1 exam every benefit period/12 months. $30 maximum benefit per visit if use a Non-Network Provider.
	Glasses	No charge	Total cost less $45 Reimbursement for frames and $25 Reimbursement for Single lenses, $40 Reimbursement for bifocal lenses and $55 Reimbursement for trifocal lenses.	Coverage is limited to 1 set of glasses every benefit period/12 months.
	Dental check-up	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Hearing aids

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (855) 748-1805. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

ATTN: Grievances and Appeals
P.O. Box 518
North Haven, CT 06473-0518

Department of Labor's Employee Benefits Security Administration
(866) 444-EBSA (3272)
www.dol.gov/ebsa/healthreform

New Hampshire Insurance Department
21 So Fruit St
Suite 14
Concord NH 03301
(800) 852-3416

Additionally, a consumer assistance program can help you file your appeal. Contact
New Hampshire Department of Insurance
21 South Fruit Street, Suite 14
Concord, NH 03301
(800) 852-3416
www.nh.gov/insurance
consumerservices@ins.nh.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy <u>does provide</u> minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage <u>does meet</u> the minimum value standard for the benefits it provides.**

Language Access Services:

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwol íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card..

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,900
- **Patient pays** $3,650

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$50
Coinsurance	$1,600
Limits or exclusions	$0
Total	$3,650

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: www.anthem.com or (855) 748-1805.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,700
- **Patient pays** $2,700

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Copays	$200
Coinsurance	$300
Limits or exclusions	$200
Total	$2,700

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.anthem.com or (855) 748-1805.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co payments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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